

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare recertification survey conducted at your facility 11/3/08 through 11/7/08. The census was 133 residents. The sample size was 28 residents and included three closed records. Complaint #NV00019293 was substantiated with no deficiencies. Complaint NV00019314 was substantiated with no deficiencies. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.	F 000			
F 155 SS=D	The following deficiencies were identified: 483.10(b)(4) NOTICE OF RIGHTS AND SERVICES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff respected resident choice to refuse a shower for 1 of 28 residents (#12).	F 155			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 155	<p>Continued From page 1</p> <p>Findings include:</p> <p>Resident #12 was admitted to the facility on 3/15/05 with diagnoses that included debility, chronic airway obstructive disease, lumbago, depression, anxiety, hypertension, osteoarthritis, and pain.</p> <p>Review of Resident #12's activities of daily living record for the month of July 2008 revealed the following entry dated 7/7/08: "(Resident) given shower in shower chair. Patient started to yell and shout including trying to climb out of it. Refused to shower after she was in chair - shower given anyway. Son was aware of her screaming and shouting."</p> <p>On 11/4/08 at 1:45 PM, Resident #12 was interviewed. She stated that the only problem she had was when she was on C-hall and she did not want to take a shower in the shower chair. She explained that because she is thin, the shower chair is very uncomfortable and she preferred to take a shower in her wheelchair. She stated that a couple months ago when she refused to shower in the shower chair, the certified nursing assistants (CNA) working with her picked her up under the arms and roughly placed her into the shower chair and stated that she was going to take a shower. Resident #12 stated that she was screaming and shouting that she did not want to take a shower. Resident #12 stated that her son came in during that time and heard her screaming and came to see why she was so upset. Resident #12 stated that she reported the incident and the CNAs to the nurse. She did not remember the name of nurse she spoke with.</p>	F 155			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 155	Continued From page 2 On 11/6/08, at 2:13 PM, Resident #12's son was interviewed. He stated that he remembered the shower incident. He stated that his mother was still very agitated and upset when he arrived at the facility. He stated that it was explained to him that his mother had not wanted to shower, and the shower was given anyway. He stated that he reported the rough treatment to the charge nurse and that he saw the charge nurse talking with the CNAs. He was unable to recall the name of the charge nurse. On 11/6/08, at 2:30 PM, the Director of Nurses (DON) was interviewed. She stated that the incident alleging rough treatment of Resident #12 and being showered against her will was not reported to her. She stated that the policy was that all allegations of mistreatment are reported and investigated. She stated that the residents have a right to refuse showers or any treatment at any time. She stated that if a resident prefers to take a shower in a wheelchair, that can be accommodated. She explained that the shower would need to be taken in the evening to allow the wheelchair to dry overnight.	F 155			
F 164 SS=D	Cross reference Tag F 225 Staff Treatment of Residents 483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this	F 164			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 164	<p>Continued From page 3</p> <p>does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the confidentiality of resident records and failed to ensure residents were not exposed during transport to showers for 2 of 28 residents (#27 and #28)</p> <p>Findings include:</p> <p>On the afternoon of 11/5/08, RN #3 was observed in the F Hall leaving the medication cart to take medications into a resident's room several doors up and on the opposite side of the hall from where the RN had left the medication cart. The medication cart was left unattended, unlocked with the medication administration record (MAR) on top of the cart. The MAR was open revealing</p>	F 164			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 164	<p>Continued From page 4</p> <p>the medication information of one resident to persons passing by. A resident was observed down the hallway talking to a visitor.</p> <p>Approximately three to four minutes later the RN returned to the medication cart. The RN immediately closed the medication record book while stating she should not have left the record open to view.</p> <p>Resident #28 was admitted to the facility on 6/6/06, with diagnoses including cerebrovascular disease, hemiplegia, and diabetes mellitus. Her minimum data set (MDS) dated 6/10/08, revealed she had impaired short and long term memory loss and was totally dependent in decision making.</p> <p>On 11/3/08 at approximately 11:23 AM, Resident #28 was observed being transported from B Hall past the nurses' station and into the shower/tub room which is located adjacent to the nurse's station. The resident was transported in a shower chair by CNA #3. The resident was covered with a bath blanket and had three full sized bottles of shampoo, conditioner and lotion piled on top of her chest. The lower portion of her back and buttocks was exposed and could be seen as she was transported down the hall.</p> <p>On 11/3/08 at 11:35 AM, CNA #3 was observed taking Resident #28 back to her room in the same fashion, covered with a bath blanket, with three full sized bottles of shampoo, conditioner and lotion piled on her chest, and the lower portion of her back and buttocks exposed and visible as she was taken down the hallway.</p> <p>Upon entering the resident's room, CNA #3 was</p>	F 164			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 164	<p>Continued From page 5</p> <p>interviewed. CNA #3 stated the manner in which she had covered and transported Resident #28 was how she usually took the residents to the shower and was not aware that it was problem. CNA #3 observed Resident #28 and agreed that the resident's back and buttocks were exposed. Another nursing assistant, CNA #4 who was present during the interview, revealed she understood exposure of the resident was inappropriate and not respectful.</p> <p>Cross reference Tag F 241 Dignity Resident #27 was admitted to the facility on 1/30/08, with diagnoses including debility, depression, decubitus ulcer and atrial fibrillation. Her minimum data set (MDS) dated 8/7/08, revealed she had impaired short and long term memory and was moderately independent in decision making.</p> <p>On 11/3/08 at approximately 11:35 AM, Resident #27 was observed being pulled backwards down the D unit hallway in a shower chair. She was covered in a shower blanket and a sheet. The upper portion of her right lateral thigh was exposed and could be seen as she was pulled down the hall.</p> <p>On 11/3/08 at 11:50 AM, CNA #1, who pulled Resident #27 down the hall, was interviewed. She stated that she knew it was wrong to pull the resident backwards and was not aware that her thigh was exposed. She confirmed that she should not have pulled the resident backwards and should have made sure the resident was covered before pulling her down the hall.</p> <p>On 11/3/08, the Director of Nurses (DON) revealed that the resident's body should have</p>	F 164			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 164	Continued From page 6 been covered before transporting her down the hallway.	F 164			
F 221 SS=D	Cross reference Tag F 241 Dignity 483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to reassess the need for restraints in accordance with facility policy, failed to document the release or removal of restraints, and failed to develop appropriate care plans for the use of restraints for 2 of 28 residents (#19 and #4). Findings include: The facility's policy and procedure entitled "Physical Restraint Use" effective date 10/25/04, Section 12, revealed "Physical restraints are to be removed at least every two hours and surrounding tissues are inspected for circulation and signs of skin breakdown or irritation. The opportunity for range of motion and exercise is provided for a period of 10 minutes during each two hours the restraint in which a restraint is employed. These items will be recorded on the 24-hour Restraint Observation Record." The policy and procedure also revealed in section 17 that "The need for a physical restraint will be re-evaluated at least quarterly as part of the	F 221			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 221	<p>Continued From page 7 MDS/RAI process."</p> <p>Resident #19 was admitted to the facility on 1/19/04, with diagnoses that included paralysis agitans, dementia, urinary incontinence congestive heart failure, venous thrombosis, depression and malnutrition. The minimum data set (MDS) dated 10/2/08, indicated his cognitive skills for decision making and his short term memory were impaired. His MDS, Section P4, also indicated he used full bed rails on all sides of his bed and his chair prevented rising.</p> <p>Record review revealed that Resident #19 used a lap tray when he was out of bed in his wheelchair. Records contained physician orders for a lap tray and for "side rails x 4." A consent for use of the lap tray was dated 12/18/06 and the consent for use of four side rails was dated 2/26/06.</p> <p>A form entitled "Physical Restraint Status Report" dated 9/28/08, was signed by staff but the form was otherwise blank. On the form was written "n/a @ this time" but no other information regarding Resident #19's use and continuing need for restraints was documented on the form. Records reflected the resident was using the lap tray and the four side rails for over two years. Records revealed that the last time a Physical Restraint Status Report had been completed by nursing staff was 3/30/08.</p> <p>On 11/6/08, a Certified Nurses Assistant was interviewed. She reported that the Resident #19 had removed the lap tray independently at times, but he could not consistently remove the tray without assistance. She reported that there was no record for documenting the releasing of the resident's lap tray. She was shown the form</p>	F 221			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 221	<p>Continued From page 8</p> <p>entitled "24 Hour Restraint Observation Record" and confirmed that the form was not being used for the resident. She stated the she did take the lap tray off whenever the resident needed toileting or changing of his briefs, but there was no established schedule for removal of the lap tray. She reported that no special measures were taken related to the resident's lap tray use such as range of motion. She reported that the resident had all four side rails up whenever he was in bed. She said that he had used both devices for "a long time now."</p> <p>Review of Resident #19's care plan, dated 9/28/08, revealed that he used the lap tray when out of bed and also used four side rails when in bed. There was no identified schedule for release of the lap tray. The care plan indicated the use of restraints should be avoided to the extent possible, but did not identify how to determine appropriate use. The care plan revealed restraint use would be reviewed every 90 days and as necessary. No assessment of the resident's ability to remove the lap tray was found in the records.</p> <p>On 11/6/08, the Nurse Educator was interviewed. She reported that the facility's restraint policy required quarterly assessment of the resident's need for restraint use. She confirmed that the Physical Restraint Status Report was the tool used to assess the need for continued restraint use. She confirmed that the 24 Hour Restraint Observation Record was to be used to document the release of restraints.</p> <p>Resident #4 was admitted to the facility on 3/27/08. Diagnoses included post cerebral vascular accident, hypothyroidism, diabetes mellitus, end stage renal disease, and dementia.</p>	F 221			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 221	<p>Continued From page 9</p> <p>She had left sided paralysis, was basically aphasic, and was receiving dialysis treatment three times a week through a central line.</p> <p>Review of the record disclosed a physician order written on 10/1/08 for "Mittens, may use restraint to prevent pulling of the dialysis port," a pre-restraint assessment, and a signed consent for the mittens. The record lacked documentation of a care plan addressing the use of the mittens.</p> <p>On 11/3/08 at 10:10 AM, a mitten was observed on the right hand of Resident #4. The left hand was paralyzed due to the effect of a previous cerebral vascular accident.</p> <p>When interviewed on 11/3/08 at 11:15 AM, a registered nurse revealed that the mitten was removed whenever someone provided any type of care for Resident #4. The mitten was replaced when the staff person left the room. She acknowledged that the removal and replacement of the mitten was not documented anywhere. She did not know when the mitten had last been removed. The registered nurse acknowledged that a care plan for the mitten had not been developed.</p> <p>Review of the facility policy on restraints revealed that alternatives should be care planned by the Interdisciplinary Committee. Response to the alternatives should be documented and should the alternatives fail, then a physical restraint would be employed. The physical restraint was to be removed a least every two hours with observation of the area and motion and exercise implemented. This data was to be recorded on the 24 hour Restraint Observation Record. The policy also stated that the use of the restraint was</p>	F 221			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 221	Continued From page 10 to be care planned. The facility failed to implement their policy regarding the use of restraints.	F 221			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the facility failed to ensure that an allegation of mistreatment was reported to the administrator and investigated for 1 of 28 residents (#12).</p> <p>Findings include:</p> <p>Resident #12 was admitted to the facility on 3/15/05 with diagnoses that included debility, chronic airway obstructive disease, lumbago, depression, anxiety, hypertension, osteoarthritis, and pain.</p> <p>Review of Resident #12's activities of daily living record for the month of July 2008 revealed the following entry dated 7/7/08: "(Resident) given shower in shower chair. Patient started to yell and shout including trying to climb out of it. Refused to shower after she was in chair - shower given anyway. Son was aware of her screaming and shouting."</p> <p>On 11/4/08 at 1:45 PM, Resident #12 was interviewed. She stated that the only problem she had was when she was on C-hall and she did not want to take a shower in the shower chair. She explained that because she is thin, the shower chair is very uncomfortable and she preferred to take a shower in her wheelchair. She stated that a couple months ago when she refused to shower in the shower chair, the certified nursing assistants (CNA) working with her picked her up under the arms and roughly placed her into the</p>	F 225			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	<p>Continued From page 12</p> <p>shower chair and stated that she was going to take a shower. Resident #12 stated that she was screaming and shouting that she did not want to take a shower. Resident #12 stated that her son came in during that time and heard her screaming and came to see why she was so upset. Resident #12 stated that she reported the incident and the CNAs to the nurse. She did not remember the name of nurse she spoke with.</p> <p>On 11/6/08 at 2:13 PM, Resident #12's son was interviewed. He stated that he remembered the shower incident. He stated that his mother was still very agitated and upset when he arrived at the facility. He stated that it was explained to him that his mother had not wanted to shower, and the shower was given anyway. He stated that he reported the rough treatment to the charge nurse and that he saw the charge nurse talking with the CNAs. He was unable to recall the name of the charge nurse.</p> <p>On 11/6/08 at 2:30 PM, the Director of Nurses (DON) was interviewed. She stated that the incident alleging rough treatment of Resident #12 and being showered against her will was not reported to her.</p> <p>Review of the facility policies for abuse prohibition revealed the facility's procedures for investigating and reporting resident incidents. These procedures included that all reports of potential abuse were to be reported and thoroughly investigated. The procedures also indicated that investigation reports were to be sent to the state licensing bureau within five days.</p> <p>Cross reference Tag F 155 Notice of Rights and Services</p>	F 225			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 241 SS=D	<p>483.15(a) DIGNITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure residents were transported in the hallways to the shower room in a manner that was respectful and maintained their dignity for 2 of 28 residents. (#27 and #28)</p> <p>Findings include:</p> <p>Resident #27 was admitted to the facility on 1/30/08, with diagnoses including debility, depression, decubitus ulcer and atrial fibrillation. Her minimum data set (MDS) dated 8/7/08, revealed she had impaired short and long term memory and was moderately independent in decision making.</p> <p>On 11/3/08 at approximately 11:35 AM, Resident #27 was observed being pulled backwards down the D unit hallway in a shower chair. She was covered in a shower blanket and a sheet. The upper portion of her right lateral thigh was exposed and could be seen as she was pulled down the hall.</p> <p>On 11/3/08 at 11:50 AM, CNA #1, who pulled Resident #27 down the hall, was interviewed. She stated that she knew it was wrong to pull the resident backwards and was not aware that her thigh was exposed. She confirmed that she should not have pulled the resident backwards</p>	F 241			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 241	<p>Continued From page 14</p> <p>and should have made sure the resident was covered before pulling her down the hall.</p> <p>On 11/3/08, the Director of Nurses (DON) revealed that the resident's body should have been covered before transporting her down the hallway.</p> <p>Resident #28 was admitted to the facility on 6/6/06, with diagnoses including cerebrovascular disease, hemiplegia, and diabetes mellitus. Her minimum data set (MDS) dated 6/10/08, revealed she had impaired short and long term memory loss and was totally dependent in decision making.</p> <p>On 11/3/08 at approximately 11:23 AM, Resident #28 was observed being transported from B Hall past the nurses' station and into the shower/tub room which is located adjacent to the nurse's station. The resident was transported in a shower chair by CNA #3. The resident was covered with a bath blanket and had three full sized bottles of shampoo, conditioner and lotion piled on top of her chest. The lower portion of her back and buttocks was exposed and could be seen as she was transported down the hall.</p> <p>On 11/3/08 at 11:35 AM, CNA #3 was observed taking Resident #28 back to her room in the same fashion, covered with a bath blanket, with three full sized bottles of shampoo, conditioner and lotion piled on her chest, and the lower portion of her back and buttocks exposed and visible as she was taken down the hallway.</p>	F 241			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 241	Continued From page 15 Upon entering the resident's room, CNA #3 was interviewed. CNA #3 stated the manner in which she had covered and transported Resident #28 was how she usually took the residents to the shower and was not aware that it was problem. CNA #3 observed Resident #28 and agreed that the resident's back and buttocks were exposed. Another nursing assistant, CNA #4 who was present during the interview, revealed she understood exposure of the resident was inappropriate and not respectful.	F 241			
F 281 SS=D	Cross reference Tag F 164 Privacy and Confidentiality 483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure medications were administered in accordance with professional standards of practice for 1 of 28 residents (#26), failed to ensure wound care was provided in accordance with professional standards of practice for 1 of 28 residents (#18), and failed to ensure that contradictory orders were clarified by staff for 1 of 28 residents (#1). Findings include: Resident #26 was admitted to the facility on 10/2/08, with diagnoses including dementia, adult failure to thrive, chronic airway obstruction and depression. Record review revealed she also had oral thrush (oral candidiasis).	F 281			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 16</p> <p>On 11/4/08, licensed practical nurse (LPN) #3 was administering medications to Resident #26. The resident was first administered Nystatin suspension, an antifungal medication, for oral thrush. The nurse advised the resident to swish the medication and swallow it. The resident took less than five seconds to swish and swallow the medication. The LPN did not make sure the residents mouth was cleansed prior to Nystatin suspension administration and did not encourage the resident to try to hold the medication in her mouth for a few minutes prior to swallowing.</p> <p>The Nursing 2006 Drug Handbook revealed that the patient's mouth should be clean of debris before administering Nystatin suspension and the patient should hold the suspension in her mouth for several minutes before swallowing it. The Internet Drug Index and the Geriatric Dosage Handbook 12th Edition also advised that Nystatin suspension should be kept in the mouth as long as possible before swallowing. The Internet Drug Index advises that the patient avoid eating for five to ten minutes following administration of Nystatin. The resident was waiting for breakfast and was not advised to wait five minutes before eating.</p> <p>Resident #26 was given Advair, an inhaler, immediately following the administration of Nystatin. The resident took the prescribed number of inhalations. The nurse did not ask the resident to rinse her mouth following the inhalations. The 2006 Nursing Drug Handbook advises that patients must rinse their mouths after inhalations are completed to prevent oral candidiasis (oral thrush). The resident had oral thrush.</p>	F 281			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 17</p> <p>On 11/4/08, LPN #3 was interviewed. She acknowledged that Resident #26 should have rinsed her mouth following the administration of Advair. She also acknowledged that the resident's mouth needed to be clean before administering Nystatin suspension and that she needed to remind the resident to try to hold the suspension in her mouth for a few minutes for the drug to be effective.</p> <p>Resident #18 was admitted to the facility on 9/9/08, with diagnoses including cerebral embolism with cerebral infarction, malignant neoplasm of rectosigmoid junction, secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes, hypertension, anemia, hyperlipidemia and tobacco use.</p> <p>On 11/5/08 at 8:15 AM, Resident #18 was interviewed. The resident revealed he had experienced a problem with his wound care when one nurse used a straw off of his bedside table to insert packing into his wound. The resident indicated a long Q-Tip was usually used and knew that it was not right for the nurse to use the straw. He had been worried that he might get an infection. The resident thought that the nurse was in a hurry and she did not come in with all the supplies she needed to do his wound care. The resident reported that it had happened only once and that he had filed a complaint/grievance, but was not sure of the outcome of the complaint.</p> <p>Review of Resident #18's grievance/incident documentation revealed the resident's statement dated 9/22/08 that was consistent with the information revealed during the resident interview on 11/5/08. A written statement by LPN #7 included in the grievance/incident documentation</p>	F 281			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	Continued From page 18 confirmed that the practice occurred on the morning of 9/21/08, as the resident had described. Resident #1 was admitted to the facility on 8/1/08 with diagnoses including traumatic brain injury, sacral decubitus ulcer, cardiac arrest, polytrauma to spleen, diaphragm rupture, humerus fracture, gastrostomy tube, and tracheostomy. Review of the medical record revealed orders for heel protectors while in bed, and repositioning every two hours. There were also orders for removal of the heel protectors during skin checks every shift. There was a contradictory order for skin checks once every day, and a contradictory order for a callus on right foot to be open to the air. Observation of Resident #1 at 11/5/08 during wound treatment at 11:20 AM revealed the resident was in bed without heel protectors. When the nurse (RN #1) was asked why the resident did not have on heel protectors, the nurse indicated the aides must have just done a skin check. However, in searching for the heel protectors they were found in the closet. The nurse stated there was no documentation kept by the facility as to when the heel protectors were removed or replaced. On 11/6/08 at 11 AM, Resident #1 was observed lying on her back in bed without her heel protectors in place. RN #1 was asked about the heel protectors and she found them and put them on the resident. At 1:00 PM on 11/6/08, the resident was observed lying on her back in the same position as she was at 11:00 AM.	F 281			
F 314 SS=D	483.25(c) PRESSURE SORES	F 314			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 19</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure wound care was provided in order to prevent infection of a wound for 1 of 28 residents (#9).</p> <p>Findings include:</p> <p>Resident #9 was admitted to the facility on 8/28/08 with diagnoses of cerebrovascular disease, debility, congestive heart failure, anemia, decubitus ulcer, chronic airway obstruction, hypertension and peripheral vascular disease.</p> <p>On 11/3/08 at 2:40 PM, licensed practical nurse (LPN) #2 was observed providing wound care to Resident #9. LPN #2 donned non-sterile gloves, poured normal saline into the cap of the normal saline bottle, dipped gauze into the cap and cleansed the resident's wounds. The gauze was re-dipped into the cap when another wound area was cleansed. LPN #2 removed her gloves and left the room to get additional supplies from the treatment cart. When the nurse returned, she put on non-sterile gloves, retrieved a tube of Santyl ointment from the resident's overbed table, and applied the ointment directly from the tube to</p>	F 314			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	Continued From page 20 several wound areas that had been cleansed. The nurse then spread the ointment with her gloved fingers, placed non-stick gauze over the wounds, and hesitated. Without changing her gloves she went to the resident's night/television stand, dug through the drawer with her gloved hands and removed a roll of tape. LPN #2 then secured the dressing with the tape and returned the tape to the drawer. LPN #2 then poured the remainder of the normal saline in the cap back into the normal saline bottle, re-capped the the bottle, and placed the bottle of normal saline back in the resident's night/television stand. The LPN returned the the of Santyl ointment to the resident's overbed table. When the LPN left the resident's room she removed her gloves and used sanitation gel to clean her hands.	F 314			
F 329 SS=D	483.25(I) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	F 329			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 21</p> <p>as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure medications were discontinued as ordered by the physician or recommended by the consultant pharmacist for 2 of 28 residents (#3 and #18)</p> <p>Findings include:</p> <p>Resident #3 was admitted to the facility on 9/1/08 following an acute care stay. Diagnoses included diabetes mellitus, hypertension, hypothyroidism and osteoarthritis. He was also experiencing an incomplete quadriplegia following a fall after neck, spine and hip surgery.</p> <p>Review of the record revealed a physician order written on 9/1/08, for Heparin 5000 units subcutaneous twice a day and to discontinue the Heparin when the resident ambulated. On 10/13/08, an order for physical therapy five times a week for thirty days was written for Resident #3.</p> <p>During the survey Resident #3 was observed ambulating in the hall with the assistance of the physical therapist.</p>	F 329			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 22</p> <p>Review of the record revealed a note dated 9/29/08, to the attending physician from the consultant pharmacist. In the note, the pharmacist recommended the discontinuation of the Heparin, that the typical duration was 7-14 days due to immobility, and that the resident self-propelled in his wheelchair. The physician agreed to the recommendation on the form on 10/19/08.</p> <p>In an interview with the Director of Nurses (DON) and the Nurse Educator on 11/3/08, the actions of the facility based on the recommendations by the pharmacist were explained. When the facility received the pharmacist recommendation, the DON talked with the physician involved and, if he was in agreement, a verbal order for the change would be written by the nurse. After investigating the situation, the Nurse Educator acknowledged that the written order was forgotten.</p> <p>The record revealed a second physician order written on 9/1/08. The second order was for Declomycin (an antibiotic) 600 mg by mouth two times daily as evidenced by infection. At the time of the survey, Resident #3 was continuing to receive the antibiotic.</p> <p>RN #3, who was passing medications on the resident's hall, was interviewed on 11/4/08. The interview revealed that that RN #3 did not know why Resident #3 was receiving the Declomycin.</p> <p>The record lacked evidence that the pharmacist had reviewed the prolonged use of the antibiotic for over 60 days. The antibiotic was noted on the admission report to the facility and indicated that Resident #3 had just finished a 10 day course of the medication for a urinary tract infection. A</p>	F 329			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	Continued From page 23 progress note by the physician dated 9/16/08, read "SIADH? check labs/discontinue Declomycin." The record lacked documentation of an order on 9/16/08 to discontinue the antibiotic.	F 329			
F 371 SS=E	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility did not ensure that food was stored and prepared under sanitary conditions. Findings include: During an inspection of the facility's kitchen on 11/3/08 at 9:00 AM, the following observations were made: Food temperature log: No food temperatures had been taken or recorded at the breakfast tray line. Refrigerators: A bowl of potato salad with a loose lid was labeled 10/28/08; an opened container of sour cream was labeled 10/22/08; peeled boiled eggs were in an open bag with the date of 10/30/08; opened jars of salsa and teriyaki sauce had no labels; a bowl of cooked beef was covered	F 371			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 24 with a torn foil cover; the label on a container of luncheon meat read PBJ 10/30; there was a bowl of beans and pork dated 10/30 in the juice refrigerator. The dietician indicated that the facility's policy was to discard prepared food items after three days and to label all opened food containers. Food storage: Opened boxes of chocolate fudge icing mix, quick oats, and ice cream cones did not have dates; a opened box of cheesecake filling mix was dated 6/1/08 and an opened bag of graham cracker crumbs was dated 9/14/08; small containers of beef soup base were undated, and one of the containers had a sliced cut through the plastic lid and foil cover; a large container of plastic-wrapped cookies prepared for snacks were dated 10/30/08. Freezer: Three ice cream cup lids were open; boxes were stacked up to the ceiling. Menus: Substitutions were not consistently recorded and kept on record for six months per facility policy.	F 371			
F 431 SS=E	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 431			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431	<p>Continued From page 25</p> <p>appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review, the facility failed to store drugs in a manner that would prevent access by unauthorized persons during six observations of five nurses, failed to properly label medication vials with the date they were opened and failed to dispose of outdated medications.</p> <p>Findings include:</p> <p>1. On 11/3/08 at approximately 3:12 PM, the medication cart on E unit was observed to be unattended. The medication cart drawers were easily opened and the medications of the E unit residents were easily removed from the cart.</p>	F 431			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431	<p>Continued From page 26</p> <p>Licensed Practical Nurse (LPN) #2 was observed on the far side of the nurses station at the entry of C unit. She did not observe the surveyors at her medication cart opening the cart drawers.</p> <p>LPN #2 was interviewed on 11/3/08 at approximately 3:20 PM. She stated that she should have locked the cart and confirmed that the facility's policy required that the cart be locked when left unattended. She stated that she forgot to push the star button which would have locked the cart. She stated that the cart was capable of locking automatically, but did not know how many minutes the cart took to lock.</p> <p>2. On 11/4/08 at approximately 8:10 AM, LPN #3 was observed to leave the medication cart unlocked and unattended during medication pass. She prepared medications for Resident #25 and entered her room to administer the medications. She walked behind the resident's privacy curtain to administer the medications and was unable to see the cart. The cart drawers were able to be opened and the D unit residents medications were exposed and easily removed from the cart.</p> <p>LPN #3 acknowledged that she forgot to lock the cart and stated that it was the facility's policy to lock the cart when when it was unattended. She did not know how long it took for the medication cart to automatically lock.</p> <p>3. On 11/6/08 at approximately 2:00 PM, LPN #1 was passing medications on E unit. He entered a resident's room and closed the door to the room. The medication cart was found to be unlocked while he was in the resident's room. The medication cart drawers were easily opened and the E unit resident's medications were easily</p>	F 431			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431	<p>Continued From page 27 removed from the cart.</p> <p>LPN #1 was interviewed on 11/6/08, and stated that he forgot to lock the cart. He confirmed that it was the facility's policy to lock the medication cart when it was out of the nurses sight.</p> <p>4. On 11/6/08 between 9:10 AM and 9:15 AM, the medication cart on C-hall was opened by LPN #4 three times to access medications. Three times it was observed that LPN #4 left the medication cart unlocked and unattended. On one occasion, a registered nurse locked the medication cart after LPN #4 left it unlocked. The medication cart drawers were easily opened and the residents' medications were easily removed from the cart.</p> <p>On 11/6/08 at 9:15 AM, LPN #4 was interviewed. She stated she should have locked the med-cart before leaving it. She stated that she thought it self-locked in five minutes.</p> <p>5. On 11/6/08 at approximately 2:10 PM, LPN #2 was observed to leave the medication cart unlocked and unattended during medication pass. The medication cart drawers were easily opened and medication removed before LPN #2 returned to the cart. LPN #2 stated she should have locked the med-cart before leaving the medication cart to pass medications.</p> <p>6. On the afternoon of 11/5/08, RN #3 was observed in the F Hall leaving the medication cart to take medications into a resident's room on the opposite side of the hall from where the RN had left the medication cart. The medication cart was unlocked. A resident was observed down the hallway talking to a visitor.</p> <p>This surveyor opened the drawers of the</p>	F 431			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431	<p>Continued From page 28</p> <p>medication cart and had access to resident medications. Approximately three to four minutes later the RN returned to the medication cart. The RN commented that she should have locked the cart before leaving it.</p> <p>On 11/5/08, the Director of Nurses (DON) was informed that unlocked medication carts were observed. She confirmed that the facility's policy was to keep the medication cart locked when it was left unattended by the nurse. She was unsure as to the exact number of minutes it took the medication carts to automatically lock, but later provided the MMI Med Cart programming guide which revealed that the locking system was set to relock after five minutes.</p> <p>Review of the policy and procedure entitled "Medication Administration General Guidelines" Section 7.1 revealed "During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse. No medications are to be kept on top of the cart. The cart must be clearly visible to the personnel administering medications when unlocked."</p> <p>On 11/4/08 at 11:00 AM, the B Hall medication cart was observed. Observation of the medication cart revealed the following:</p> <p>One unopened vial of Cyanocobalamin that was not labled/designated for house use or for a particular resident.</p> <p>Multiple bottles of liquid medications that were opened and undated including: Guaifenesin DM cough syrup, Loperamide Hydrochloride, Colace, Potassium Chloride, Tylenol, Lactulose and Milk of Magnesia.</p>	F 431			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER RENOWN SKILLED NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1835 ODDIE BLVD SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431	<p>Continued From page 29</p> <p>On 11/4/08 at approximately 10:30 AM, an observation of the medication cart for "C" Hall was made. The following was found:</p> <p>A vial of injectable Vitamin B12 that had expired 10/08.</p> <p>A vial of Humalog Insulin that had been opened, but not dated.</p> <p>A vial of Novolin N Insulin that was dated as having been opened on 9/21/08.</p> <p>A vial of Novolin R Insulin that was opened and dated 10/2/08.</p> <p>LPN #6 was interviewed at 10:45 AM. LPN #6 reported that opened vials were to be discarded 30 days after being opened.</p>	F 431			